DOCUMENT RESUME

ED 251 220 PS 014 755

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TITLE Social Competence in Young Children: A Developmental Perspective.
PUB DATE Apr 84
NOTE 31p.; Portions of this paper were presented at the Annual Meeting of the American Educational Research Association (68th, New Orleans, LA, April 23-27, 1984).
PUB TYPE Reports - Research/Technical (143)

EDRS PRICE MF01/PC02 Plus Postage.
DESCRIPTORS Affective Behavior; *Children; *Disabilities; *Family Influence; *High Risk Persons; *Interpersonal Competence; Mothers; *Social Networks
IDENTIFIERS *Dyadic Interaction Analysis

ABSTRACT

Aspects of a child's social environment, in this case those connected with networks and dyadic interaction, are influenced by different maternal and child characteristics. The young child's social network is influenced by at-risk status but not by chronological age. Not only do families with handicapped infants receive more support from formal social services, but they also receive more help from their kin. Maternal responsivity is influenced by the mental age of the child. In contrast, affective responses are not linked to mental age, but are related to at-risk status. Mothers of handicapped infants exhibit less positive affect and are less responsive to their child's smiling than are mothers of nonhandicapped infants. Given this complex of findings, it might be expected that maternal behavior or network composition would influence affective development and peer-oriented interactions in the at-risk or handicapped child more than would cognitive functioning. Individual differences in maternal affect or in network composition might predict later social competency; studies are needed to investigate specific links between social and affective features of the environment and the child's later social competence. (RH)

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Social Competence in Young Children: A Developmental Perspective

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The research reported in this paper was supported by the Special Education Program, U.S. Department of Education, under the auspices of an early childhood research institute. Drs. Linda Michaelson, Richard Brinker, and Michael Lewis are to be thanked for their comments on earlier drafts of this paper. Thanks are also due Lorraine Luciano and Rosemary Deibler for their help in manuscript preparation. Portions of this paper were presented at a symposium on Issues in Developmental Assessment: The Social Domain, presented at the American Educational Research Association meetings, New Orleans, April 1984. A more complete discussion of these issues is presented in the following chapters: Brooks-Gunn, J. & Luciano, L. (1985, in press), Social competence in young handicapped children: A developmental perspective. In M. Sigman (Ed.), Children with dual disabilities.; Brooks-Gunn, J. (1984), Early dyadic interactions with the handicapped: Special infants or special parents? In W. K. Frankenburg, R. Emde, and J. Sullivan (Eds.), Early identification of children at risk: An international perspective. Requests for additional information may be addressed to: Dr. Brooks-Gunn, Educational Testing Service, Princeton, New Jersey, 08541.

Running Head: Development of Social Competence

PS 014755

Social Competence in Young Children: A Developmental Perspective

Abstract

In the present paper, two aspects of social competence will be discussed, social networks and dyadic interactions. The characteristics of the mother and of the infant as well as more general contextual features influence the frequency and nature of the child's network and interactions. Typically, early childhood research has not focused upon maternal characteristics, except in cases of mental illness, abuse, and severe economic deprivation. More recently, social isolation has been identified as a possible mediator of networks and interaction. Much of this literature focuses on the at-risk child, whose presence is believed to elicit a need for familial, social or maternal support given stigmatism, sadness, and/or difficult child rearing circumstances. Examples from research with at-risk and handicapped young children and their families are presented.

Social Competence in Young Children:
A Developmental Perspective

Jeanne Brooks-Gunn

From the moment of birth, the child is enmeshed in a social milieu, a network which, ideally, will offer security, love, and intimacy but which will also demand the acquisition and maintenance of an entire repertoire of social behaviors deemed appropriate by that particular group or culture. Social development requires growing up within a social system such that one is able to behave in socially acceptable ways.

Social skills include those abilities that enable one to analyze, understand and respond to the behavior of other individuals as well as to initiate and maintain interactions with others. Early social development encompasses at least five areas, as is shown in Figure 1--social systems and networks, social relationships and interpersonal interactions, social knowledge and self knowledge, social behavior, and emotional expression (Lewis & Brooks-Gunn, 1979). After a period of benign neglect (except from the ethologists studying attachment, social development in young children has received increasing attention in the last decade (Kagan, 1978; Emde, 1978; Lewis & Rosenbloom, 1978, 1979).

Insert Figure 1 about here

In the present paper, two aspects of social competence will be discussed, social networks and dyadic interactions. The characteristics of the mother and of the infant as well as more general contextual features influence the frequency and nature of the child's network and interactions. For example, until school, the mother is the primary determinant of the child's network. Her own characteristics and life situation dictate the network composition, over and above specific child characteristics, such as sociability, irritability, and developmental competence. The same may be said of interactions. Typically, early childhood research has not focused upon maternal characteristics, except in cases of mental illness, abuse, and severe economic deprivation. More recently, social isolation has been identified as a possible mediator of networks and interaction. Much of this literature elicit a need for familial, social or maternal support given stigmatism, sadness, and/or difficult child rearing circumstances.

Examples from my research with Michael Lewis on handicapped young children and their families will be used to illustrate the possible contributions of maternal and infant characteristics to children's networks and interactions, the milieu in which social competence originates and is sharpened.

Before doing so, however, it is important to stress the primacy of the social environment for the young child. First, different domains of development probably affect one another in complex ways. For example, the meaning of language is first learned within a specific social context. Only later is the child capable of understanding or producing language independent of social context. Therefore, even to understand linguistic development, social contextual features must be considered.

Not only does all of the young child's learning occur within a social

context, but his or her earliest knowledge is organized around social information (Sander, 1977; Stern, 1974). For example, the neonate is most likely to respond to a human face as compared to other stimuli. This is true because the face contains features that are most likely to capture the young infant's attention. The infant also has the best visual acuity for objects which are 12 to 18 inches from his eyes, the very distance between mother's and infant's face during a feeding session. Thus, the young organism may be "primed" to attend and respond to humans.

Social Systems

Turning to specific research on social systems, Bronfenbrenner (1977), as well as others, has conceptualized the network as a context in which the child behaves and develops. The social network of the child includes not only household members, but persons such as neighbors, friends, schoolmates, and kin. Social networks may influence the child either directly, through the nature and number of persons with whom the child has contact or indirectly, through the mediation of the parents (Lewis & Feiring, 1981).

It has been suggested that the social network of people and the functions that they play may change substantially over the early years. For example, as the child gets older, teachers are added to the network, and children play less with parents and more with peers. In addition, the structure of the family influences the contacts available to the child (i.e., the later-born child, unlike a first-born, may have peer friends of an older sibling). Finally, sociocultural differences may have an impact on social networks (Whiting & Whiting, 1975).

Unfortunately, little is known about the changes in children's networks over the preschool years and almost nothing is known about networks of

different types of children during this time. Instead, the value of networks for providing assistance during times of stress has been emphasized.

In our research, network composition as a function of age and disability has been studied, in terms of the age, gender, and kinship of the members comprising the children's network (Lewis, Feiring, & Brooks-Gunn, in press). One hundred and fifty children and their mothers were seen; 40 Ss were three years of age and 110 Ss were six years of age. One-half of the subjects were handicapped and one-half were normal. The handicapped sample included children diagnosed as having Down's syndrome, cerebral palsy, multiple handicaps, and developmental delays.

Mothers were asked to list persons in the categories of family, relative, friends of parents, friends of child, and others with whom the child had contact. Then, the mother was asked to determine whether or not the child had had contact with each person on a daily, weekly, monthly, bi-yearly, or yearly basis (in the last year). Two types of measures were analyzed for each category--the number of people within a child's network and the frequency of daily contact.

As can be seen in Figure 2, mothers listed approximately 26 people in children's networks. The handicapped children had more people in their network than the non-handicapped children. No differences between the three and six-year-olds were seen. With regard to specific types of people, handicapped children had more aunts and uncles, cousins, other adult relatives and babysitters, but fewer grandparents in their networks than did normal children.

Figure 3 presents the number of people in the child's network by their age, kinship, and gender. All children's networks (across handicapping

condition and age) include more adults than peers. Handicapped children had more adults in their networks than did normal children. Not surprisingly, all children had more females than males in their social networks.

Insert Figures 2 and 3 about here

In brief, handicapped children of both ages had more people in their network than did normal children. This network size difference suggests that the stereotype of the dysfunctional child being isolated from contact outside the nuclear family is not true. First, a large number of support personnel may be needed to help the immediate family care for a handicapped child, and second, parents may elicit the help of others, such as relatives, for child care or emotional support. The larger number of babysitters in the handicapped than non-handicapped child's network may reflect the parents' desire to be relieved from childcare. Mothers report that one of the major problems with having an at-risk child is the vast amount of child care required and that intervention programs are valued for their help in this area over and above education (Beckman, 1983).

One of the most important aspects of the social network is the age of the persons within it. Change in the relative number of adults and peers was expected to occur as the children became older, possibly because of a decrease in the need for some functions associated with adults, e.g., care, and the increase in the need for peer-related functions, e.g. play. The expected shift did not occur for the total sample, possibly because so many preschoolers were attending daycare programs and play groups. However,

shifts were more likely to occur in the normal than the handicapped group. Handicapped children's delays may necessitate more adult contact and care-giving. In addition, the societal values in general and people's response to the risk child in particular also may affect network composition. At-risk children often are excluded from situations which would tend to promote peer interaction, even though studies of peer interaction between preschool at-risk and normal children suggest that, given the chance, the former are able to engage in age-appropriate social exchanges. If peer contact provides social skills different from those provided by adults (Gampel, Gottlieb, & Harrison, 1974; Greenspan, 1979), at-risk children may suffer from restrictions in peer-network contact, which need not necessarily be dictated directly by their original dysfunction. Recently, integration of at-risk children into school contexts has been based on the premise that peer interaction is necessary for social development (Guralnick, 1976).

Thus, a child may be affected by increased social networks in several ways. First, direct contact with other people may facilitate certain types of social behavior, as in the case of peers. In addition, mothers who experience stress related to the at-risk status of their child, the at-risk status of their family, or some personal experience, may be better able to provide the child with positive parenting experiences if stress is mediated by contact with network members. In such families, contact with network members may provide buffers for coping with stress due to factors such as extra care-giving demands, stigmatization, grief, and parental emotional functioning.

Relationships Within the Family

Assynchronies in early social interchanges have been associated with a

number of etiological factors, including infant characteristics such as the handicapping conditions, inattentiveness, unattractiveness, or irribility. For example, premature infants who smile late or who exhibit reduced responsivity were found to have mothers who were less likely to interact with them (Field, 1974). Infants with difficult temperaments also may experience different maternal interaction patterns and even less time in interaction with their mothers than easy babies with less difficult temperaments. Mothers are less apt to vocalize to handicapped infants who are active and distractable than handicapped infants who are less active and distractable (Brooks-Gunn & Lewis, 1981).

Perceptions alone can influence interactions. Mothers of infants sick at birth treat their infants more carefully and interact with them less, even at three months of age when the infants are completely well, than mothers of three-month-old babies who are healthy at birth. It is as though the parents believe that the children are still fragile or sick long after recovery (Cox & Lewis, 1981).

Examining maternal interactions with at-risk and normal infants provides information regarding the role of infant and maternal characteristics upon interaction problems. Mothers with handicapped or at-risk infants are more directive in their play sequences, more controlling of interactions, and take the initiative in interaction sequences more than mothers of normal infants. In a recent study of 111 young handicapped children ranging in age from 3 to 36 months (Table 1), mothers became more responsive to their infants as a function of their infants' age (Brooks-Gunn & Lewis, 1984; see Figure 4). Others have reported similar findings for mothers of normal infants. One question has to do with the role of chronological as opposed to mental age in these

relationships. In the findings just presented, it is not clear whether mothers' interactions are influenced by unique group characteristics or more general functional levels. For example, maternal responsivity was also related to infants' mental as well as chronological age (see Table 2 and Figure 4). Partial correlational analyses revealed that the infants' developmental age, not chronological age, was related to responsivity. Thus, mothers were sensitive to their children's level of functioning.

At the same time, specific types of dysfunction also affect maternal responsivity. For example, in our study, mothers exhibited more proximal behavior to cerebral palsy than Down's syndrome infants. In all likelihood, they were responding to their children's difficulty in interacting with the mothers as well as with toys by exhibiting proximal behavior.

Insert Figure 4 and Tables 1 & 2 about here

Not only may mothers of handicapped children differ with respect to responsivity, control and initiation, they may exhibit different affective patterns, as compared to mothers of normal children. One of the mother's major socialization tasks is to help the child manage his or her emotions, as well as interpret and attach meaning to the expressed emotions of the child. In terms of emotional management the mother may modulate the child's emotional responses and/or facilitate emotional expression (Brooks-Gunn & Lewis, 1981).

Modulating emotions include such processes as inhibition of a response or dampening of a response. Modulation may be especially important for the high-risk infant, who often has difficulty in this aspect of emotional

expression. For example, premature infants tend to exhibit disorganized sleep-wake patterns and a high degree of irritability and dampening. Down's syndrome infants have longer latency to cry in free-play settings but, once negative affect is elicited, take much longer to calm down. Given these problems, we might expect mothers of high-risk infants to alter their behavior to help their infants. Typically, however, mothers do not spontaneously alter their behavior. Only with intensive intervention do mothers change their interaction styles with regard to arousal modulation (Field, 1979).

Facilitation of emotions is another area in which mothers may be of assistance to their children. Handicapped infants exhibit less positive affect than same-age normal infants, as seen in Figure 5 (Brooks-Gunn & Lewis, 1982). However, mothers do not seem to facilitate positive emotional expression as evidenced by their responsivity to infants' smiles. If anything, mothers of handicapped infants are less responsive to their children's smiling behavior, as seen in Figure 6. Maternal disappointment, frustration, or expectations may be mediating factors. The point here, however, is that mothers of handicapped or at-risk infants may be less facilitative of their infants' positive affect than are mothers of normal infants.

Negative affective interactions are not seen very frequently in observational studies, given the social undesirability of such behavior (if initiated by adults). One way to look at negative exchanges is to examine mothers' responses to their children's fretting and crying. Maternal responsivity to infants' frets and cries in a free-play setting decreases with age, as seen in Figure 7. Mothers become less responsive to cries after the first six months of life, regardless of the infant's overall

amount of fretting. Perhaps mothers interpret fretting differently in the first half of the first year than in the second, the former being interpreted as a biological need (hunger, fatigue, gas, dampness), regardless of the developmental status of the child (Brooks-Gunn & Lewis, 1981).

Insert Figures 5, 6, and 7 about here

Summary

In summary, different aspects of a child's social environment, in this case those connected with networks and dyadic interaction, are influenced by different maternal and child characteristics. The young child's social network is influenced by at-risk status but not chronological age. Not only do families with handicapped infants receive more support from formal social services, but they also do from their kin. In part, this may be due to a parental need for child care relief and to the restrictions of children's interactions with peers.

Maternal responsivity is influenced by the mental age of the child, suggesting that mothers are sensitive to developmental competencies. In contrast, affective responses are not linked to mental age, but are related to at-risk status. Mothers of handicapped infants exhibit less positive affect and are less responsive to their child's smiling than mothers of non-handicapped infants. Possibly, the availability of social support does not alleviate ambivalent feelings about their child's at-risk status or their lags in developmental functioning, to which they are appropriately responsive. These feelings may have resulted in frustration or disappointment, which is expressed emotionally.

Given this complex of findings, one might expect the maternal behavior or the network composition to influence affective development and peer-oriented interactions more so than cognitive functioning, in the at-risk or handicapped child. Individual differences in maternal affect or in network composition might be predictive of later social competency. The challenge is to investigate specific links between social and affective features of the environment and later social competence (Wachs & Gruen, 1982).

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TABLE 1

Number of Subjects by Chronological Age, Mental Age, and Handicapping Condition

Age (in months)	Handicapping Condition			
	Down's Syndrome	Developmentally Delayed	Physically Impaired	Total
Chronological Age	N	N	N	N
3 to 7	16	1	0	17
8 to 16	13	4	10	27
17 to 27	14	9	16	39
28 to 36	13	7	8	28
Total	56	21	34	111
Mental Age				
3 to 7	21	3	9	33
8 to 16	21	7	7	35
17 to 27	8	5	6	19
28 to 36	0	2	1	3
Total	50	17	23	90[1]

[1] Number of subjects for whom MDI scores were available

(from Brooks-Gunn & Lewis, 1984)

Table 2

Correlations Between Maternal Responsivity Measures and Chronological and Mental Age

Responsivity Measures	Age			
	Chronological Age	Mental Age	Chronological Age (MA Controlled)	Mental Age (CA Controlled)
Total Behavior				
Maternal Responsivity/Infant Total	.31**	.41**	.04	.29**
Maternal Responsivity/Maternal Total	.48**	.61**	.03	.84*
Maternal Responsivity/Maternal Interaction	.41**	.51**	.10	.34**
Distal Behavior				
Maternal Responsivity/Infant Total	.41*	.43*	.12	.17
Maternal Responsivity/Maternal Total	.65**	.67**	.25	.31**
Maternal Responsivity/Maternal Interaction	.50**	.58**	.05	.34*

Note: The numbers of subjects for the total behavior analyses were 111 (CA), 90 (MA), and 87 (covariate analyses).

** $p < .001$

* $p < .01$

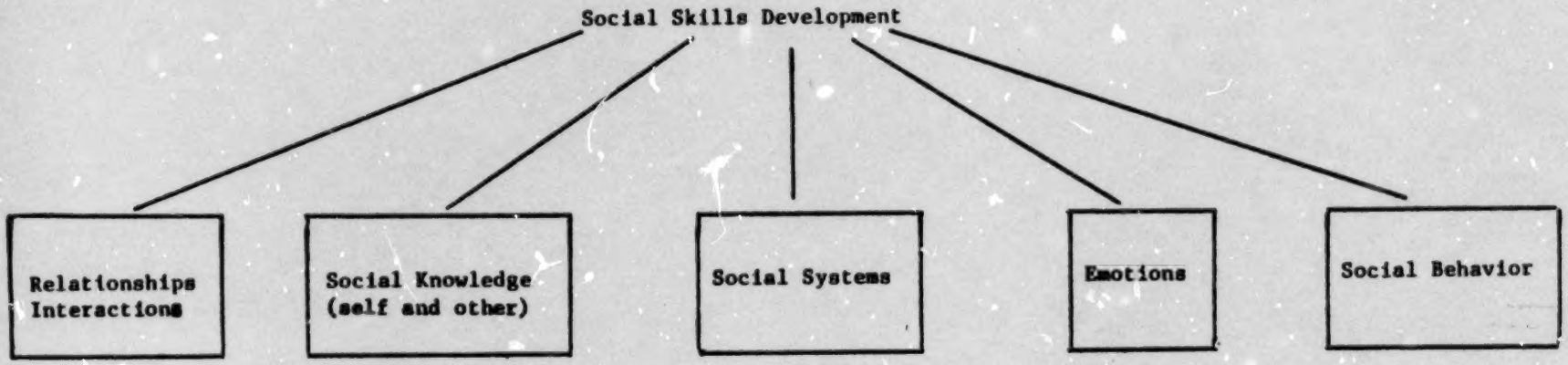

Figure 1: Dimensions of early social skills

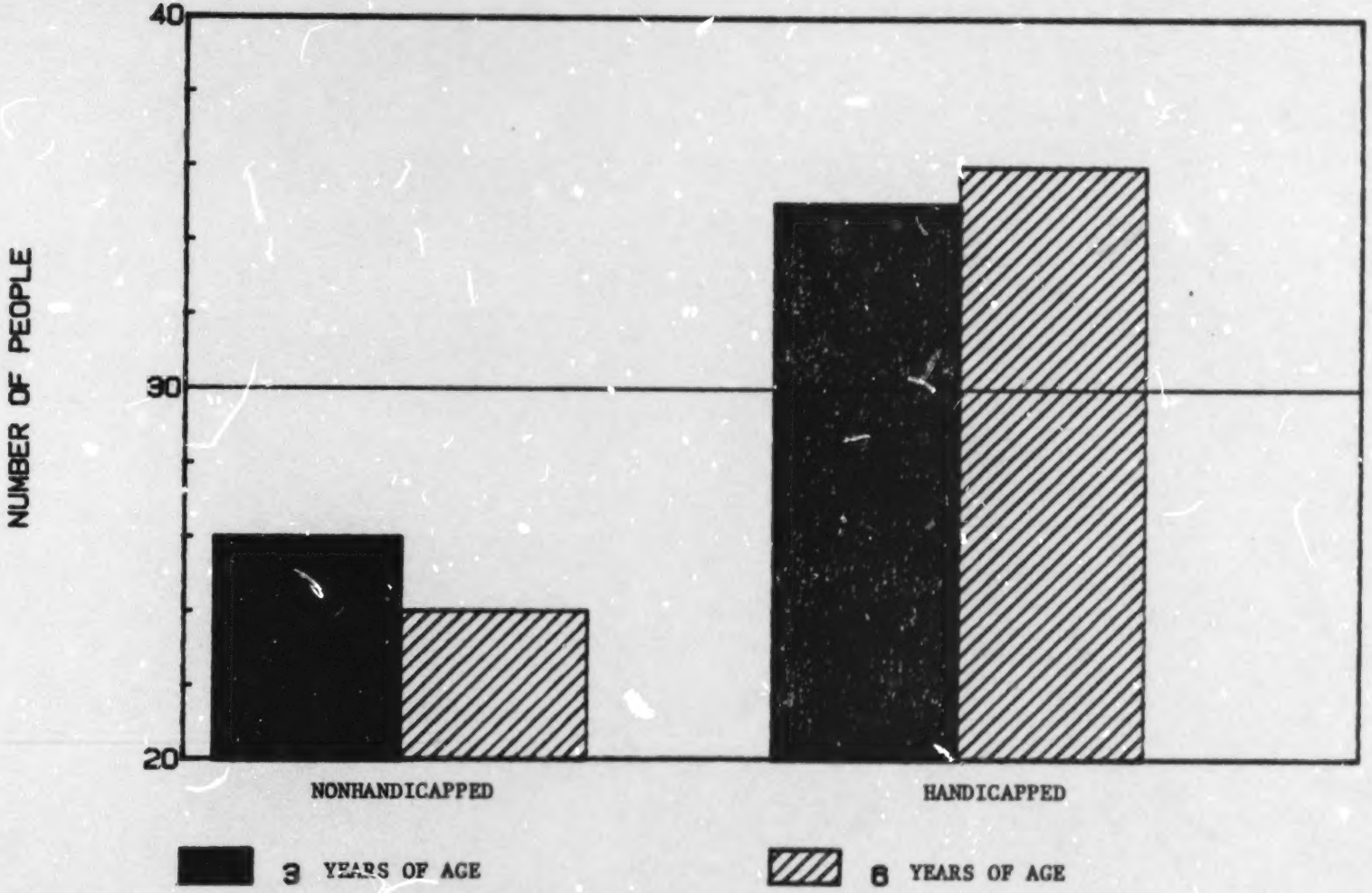

Figure 2: Number of People in Children's Social Networks by Age and Group (from Lewis, Feiring, and Brooks-Gunn, 1984)

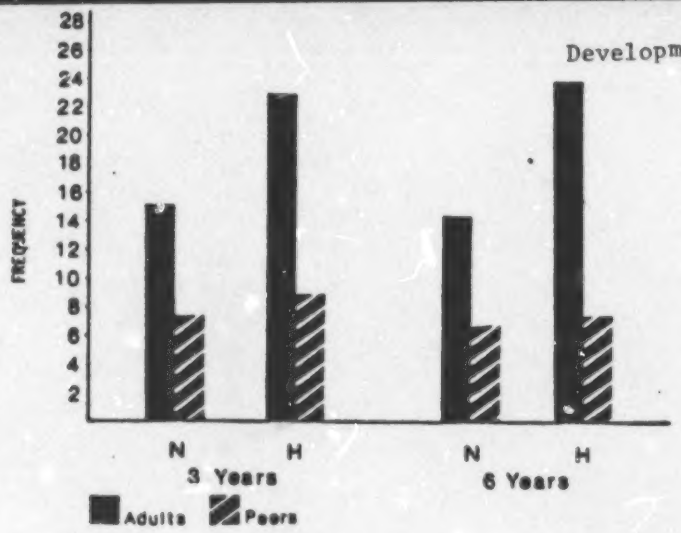

Figure 3A. Age category: Adults and peers for total number of network members.

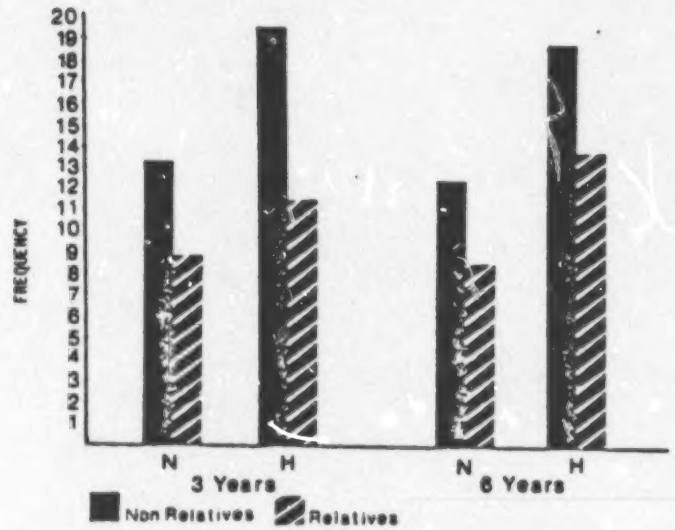

Figure 3B Kinship: Relatives and non relatives for total number of network members.

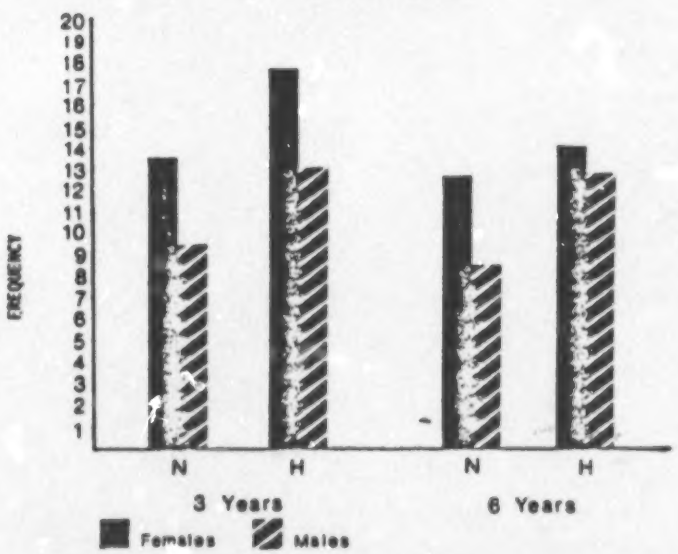

Figure 3C Gender catagory: Males and females for total number of network members. (from Lewis, Feiring, & Brooks-Gunn, 1984

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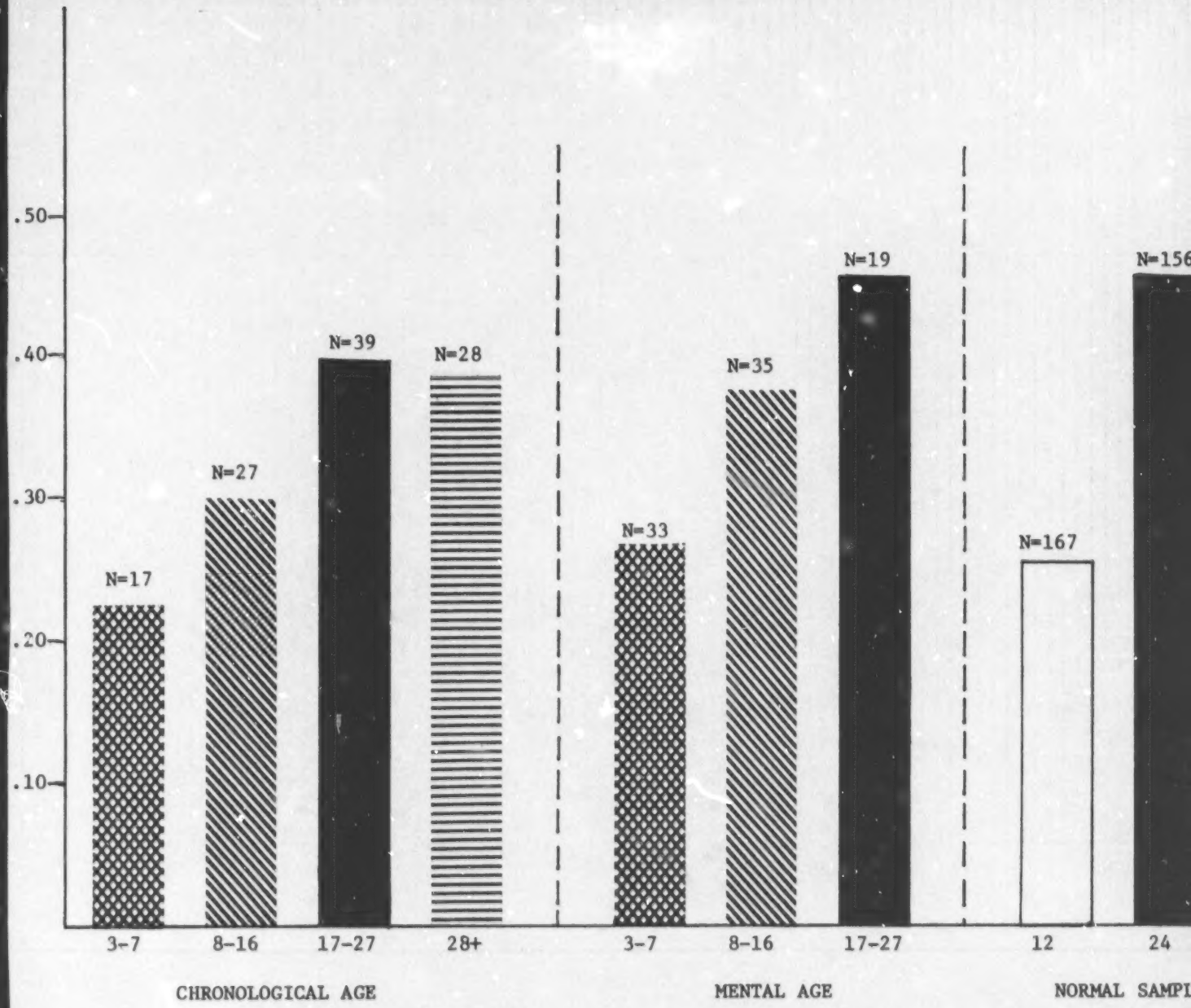

FIGURE 4: Maternal responsivity as a proportion of total maternal behavior by chronological and mental age for handicapped young children and by chronclogical age for normal children

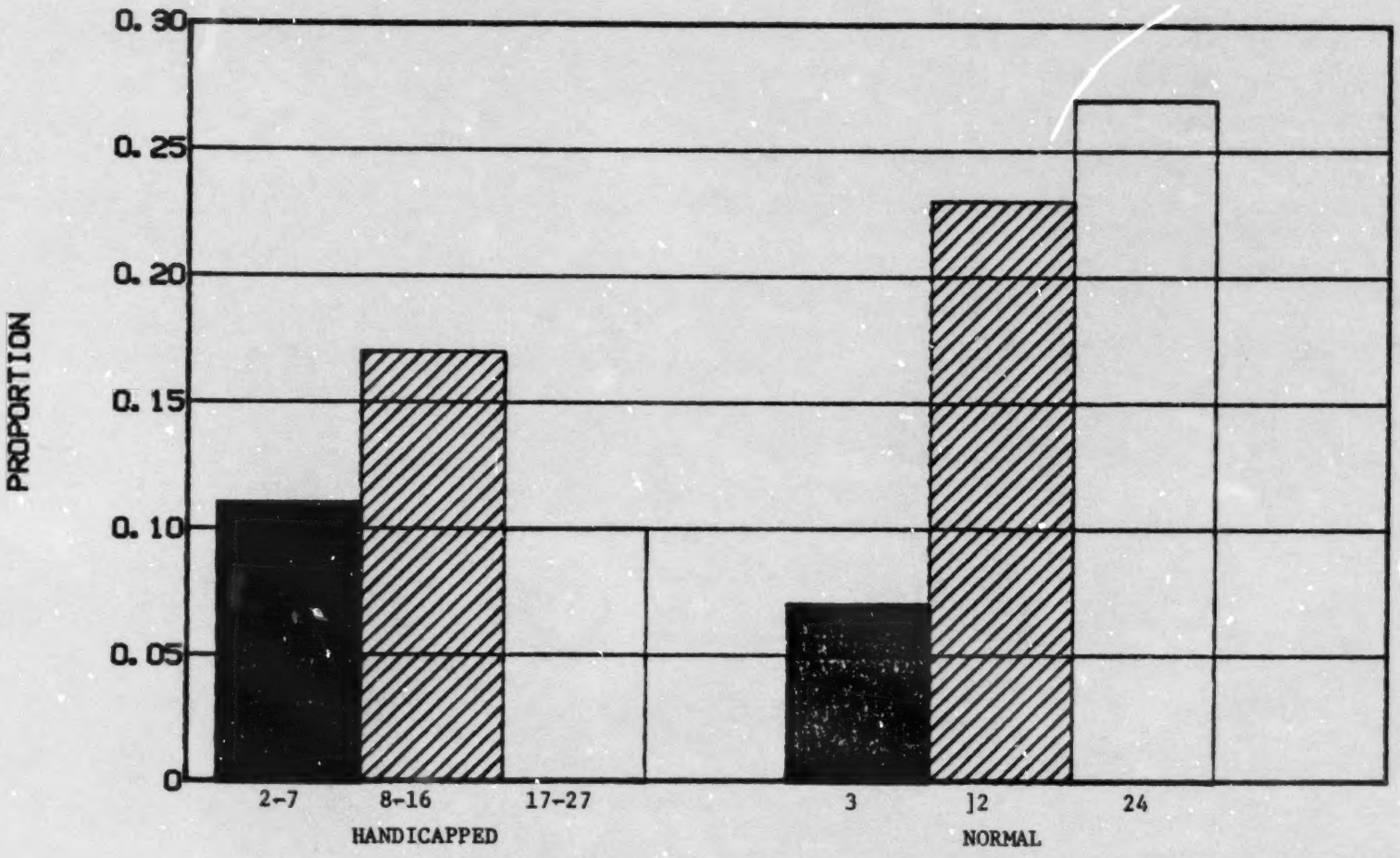

Figure 6: Proportion of Maternal Responses to Infant Smiles

(from Brooks-Gunn & Lewis, 1984)

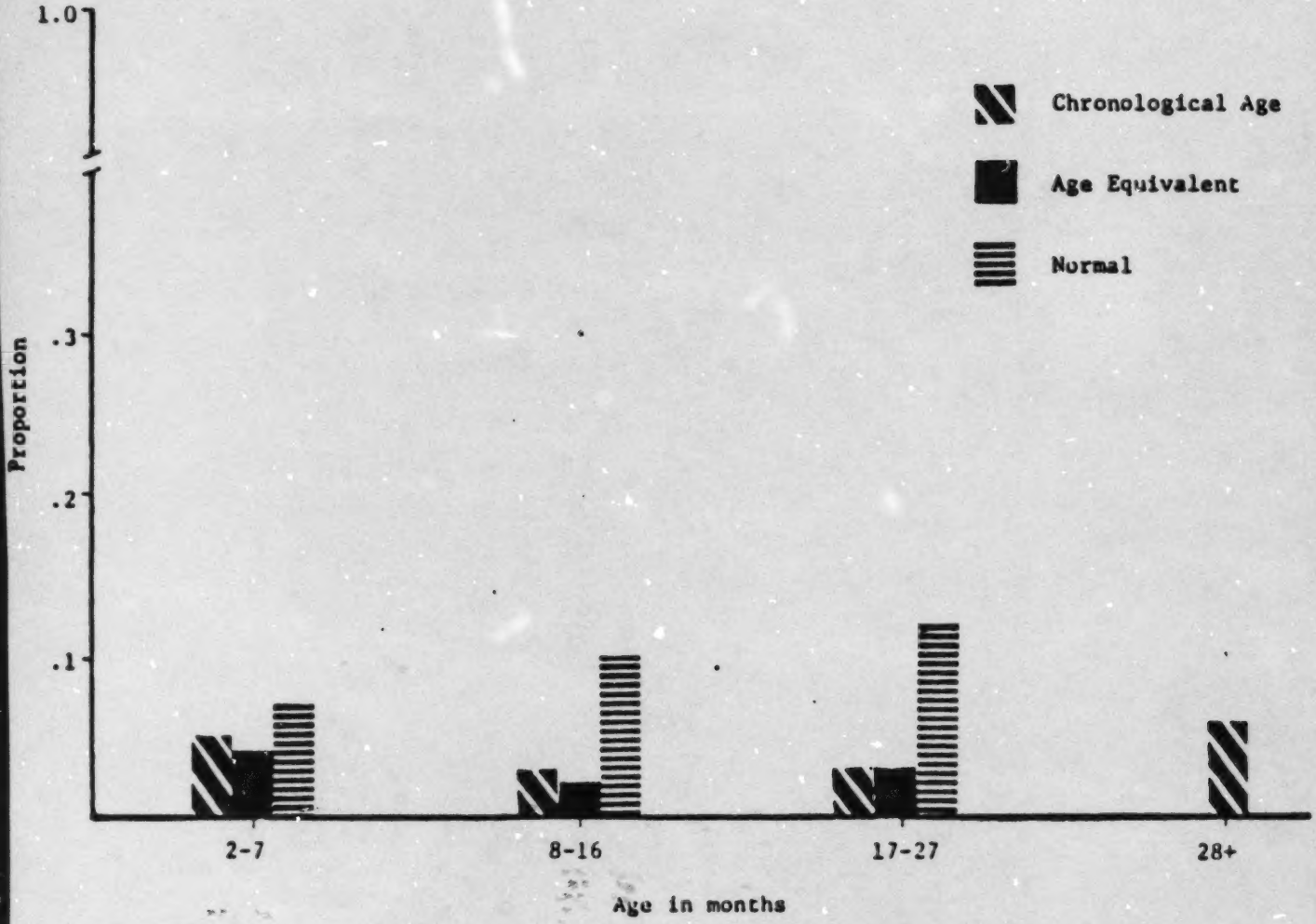

Figure 5: Infant smiles as a proportion of all behaviors: age trends.

(from Brooks-Gunn & Lewis, 1982)

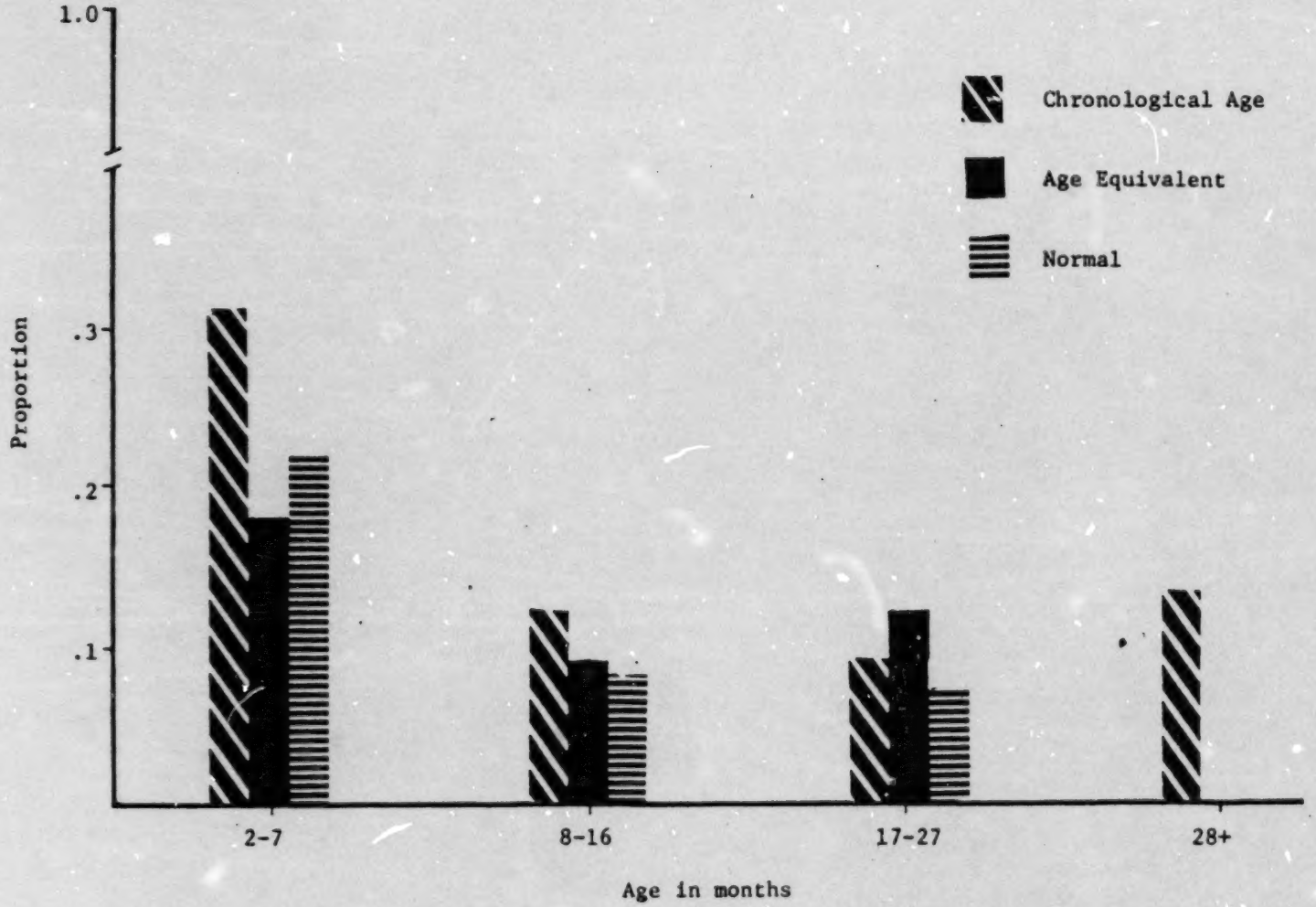

Figure 7: Maternal response to infant fret/cry as a proportion of total fret/cry behavior: age trends. (from Brooks-Gunn & Lewis, 1982)